If the Employer fails, after the timely receipt of the Employee's payment, to pay Horizon BCBSNJ on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, Horizon BCBSNJ.

When This Continuation Ends
These continued group health benefits end on the first of the following:
a) the end of the period for which the last payment is made, if the Employee stops paying.
b) the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c) the date this Policy ends or is amended to end for the class of Employees to which the Employee belonged; or
d) with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Policy.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice
This section may not apply to an Employer's Policy. The Employee must contact his or her Employer to find out if:
a) the Employer must allow for a leave of absence under Federal law in which case;
b) the section applies to the Employee.

If An Employee's Group Health Coverage Ends
Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her group health benefits insurance will be continued. Dependents' insurance may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends
Insurance may continue until the earliest of:
a) the date the Employee returns to Full-Time work;
b) the end of a total leave period of 12 weeks in any 12 month period;
c) the date on which the Employee's coverage would have ended had the Employee not been on leave; or
d) the end of the period for which the premium has been paid.

A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were insured under this Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:
a) 180 days following the date of the Employee's death; or
b) the date the Dependent is no longer eligible under the terms of this Policy.

CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE OR CIVIL UNION OR DOMESTIC PARTNERSHIP ENDS

If an Employee's marriage ends by legal divorce or annulment or the employee's civil union is dissolved or termination of a domestic partnership, the group health benefits for his or her former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under this Policy on the date the group health benefits ends. See **exceptions** below.

Exceptions
No former spouse may use this conversion right:
a) if he or she is eligible for Medicare; or
b) if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. Horizon BCBSNJ will determine if overinsurance exists using its standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health benefits ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED POLICY

The individual policy will provide the medical benefits that Horizon BCBSNJ is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health benefits under this Policy ends.

After group health benefits under this Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under this Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under this Policy.

EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN

HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the group health benefits insurance provided by this Policy. If the Employer does the following provisions apply.

IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP
Date Group Health Benefits Insurance Ends

Insurance for an Employee and his or her Dependents will end on the date the Employee becomes an HMO member.

Benefits After Group Health Benefits Insurance Ends
When an Employee becomes an HMO member, the **Extended Health Benefits** section of this Policy will not apply to him or her and his or her Dependents.

Exception:
IF, on the date membership takes effect, the HMO does not provide benefits due to:
a) an HMO waiting period
b) an HMO Pre-Existing Conditions limit, or
c) a confinement in a Hospital not affiliated with the HMO

AND the HMO provides benefits for Total Disability when membership ends

THEN group health benefits will be paid until the first of the following occurs:
a) 30 days expire from the date membership takes effect
b) the HMO's waiting period ends
c) the HMO's Pre-Existing Conditions limit expires, or
d) hospitalization ends.

IF AN HMO MEMBER ELECTS GROUP HEALTH BENEFITS INSURANCE PROVIDED BY THIS POLICY
Date Transfer To Such Insurance Takes Effect

Each Employee who is an HMO member may transfer to such insurance by written request. If he or she elects to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

Request made during an open enrollment period

Horizon BCBSNJ and the Policyholder will agree when this period will be. If an Employee requests insurance during this period, he or she and his or her Dependents will be insured on the date such period ends.

Request Made Because:
a) an HMO ends its operations
b) the Employee no longer lives, works or resides in the HMO service area

If an Employee requests insurance because membership ends for these reasons, the date he or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:
a) on or before the date membership ends, they will be insured on the date such membership ends
b) within 31 days after the date membership ends, they will be insured on the date the request is made
c) more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

Request made because an HMO becomes insolvent
If an Employee requests insurance because membership ends for this reason, the date he- or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:
a) within 31 days after the date membership ends, they will be insured on the date the request is made
b) more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

Request made at any other time
An Employee may request insurance at any time other than that described above. In this case, he or she and his or her Dependents will be Late Enrollees.

Other Provisions Affected By A Transfer

If a person makes a transfer, the following provisions, if required by this Policy for such insurance, will not apply on the transfer date:

a) an Actively at Work requirement
b) a waiting period to the extent it has already been satisfied, or
c) Pre-Existing Conditions Limitation provisions to the extent it has already been satisfied.

Charges not covered
Charges incurred before a person becomes insured will be considered Non-Covered Charges.

Right to change premium rates
Horizon BCBSNJ has the right to change premium rates when, in its opinion, its liability under this Policy is changed by interaction with an HMO plan.

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision
A Covered Person may be covered for health benefits or services by more than one Plan. For instance, he or she may be covered by this Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is covered by more than one Plan, this provision allows Horizon BCBSNJ to coordinate what Horizon BCBSNJ pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the Covered Person is covered.

DEFINITIONS
The words shown below have special meanings when used in this provision. Please read these definitions carefully. Throughout this provision, these defined terms appear with their initial letter capitalized.

Allowable Expense: The charge for any health care service, supply or other item of expense for which the Covered Person is liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this Policy is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.

Horizon BCBSNJ will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and Appropriate.

When this Policy is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, Horizon BCBSNJ will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Allowed Charge: An amount that is not more than the usual or customary charge for the service or supply as determined by Horizon BCBSNJ, based on a standard which is most often charged for a given service by a Provider within the same geographic area .

Claim Determination Period: A Calendar Year, or portion of a Calendar Year, during which a Covered Person is covered by this Policy and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:

a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
c) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
d) Group hospital indemnity benefit amounts that exceed $150 per day;

e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

"Plan" does not include:
a) Individual or family insurance contracts or subscriber contracts;
b) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
c) Group or group-type coverage where the cost of coverage is paid solely by the Covered Person except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
d) Group hospital indemnity benefit amounts of $150 per day or less;
e) School accident –type coverage;
f) A State plan under Medicaid.

Primary Plan: A Plan whose benefits for a Covered Person's health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either either "a" or "b" below exist:

a) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
b) All Plans which cover the Covered Person use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

Secondary Plan: A Plan which is not a Primary Plan. If a Covered Person is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN
Horizon BCBSNJ considers each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each Claim Determination Period the Secondary Plan(s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the "**Procedures to be Followed by the Secondary Plan to Calculate Benefits"** section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for medically necessary and appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the Covered Person as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the Covered Person as a Dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers the Covered Person as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers the Covered Person as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the Covered Person as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the Covered Person under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

a) The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.
b) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of plan which covered the other parent for a shorter period of time.
c) Birthday, as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
d) If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

a) The benefits of the Plan of the parent with custody of the child shall be determined first.
b) The benefits of the Plan of the spouse of the parent with custody shall be determined second.
c) The benefits of the Plan of the parent without custody shall be determined last.
d) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the plan of the other parent shall be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:

a) the basis on which the Primary Plan and the Secondary Plan pay benefits; and
b) whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Allowed Charge (AC), or some similar term. This means that the provider bills a charge and the Covered Person may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on an Allowed Charge is called an "AC Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the Covered Person may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the Covered Person uses the services of a non-network provider, the plan will be treated as an AC Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a "capitation". This means that then HMO or other plans pays the provider a fixed amount per Covered Person. The Covered Person is liable only for the applicable deductible, coinsurance or copayment. If the Covered Person uses the services of a non-network provider, the HMO or other plans will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

<u>Primary Plan is AC Plan and Secondary Plan is AC Plan</u>
The Secondary Plan shall pay the lesser of:
a) The difference between the amount of the billed charges and the amount paid by the Primary Plan; or
b) The amount the Secondary Plan would have paid if it had been the Primary Plan.
When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

<u>Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan</u>
If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) The amount the Secondary Plan would have paid if it had been the Primary Plan.
The total amount the provider receives from the Primary plan, the Secondary plan and the Covered Person shall not exceed the fee schedule of the Primary Plan. In no event shall the Covered Person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

<u>Primary Plan is AC Plan and Secondary Plan is Fee Schedule Plan</u>
If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:
a) The difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
b) The amount the Secondary Plan would have paid if it had been the Primary Plan.

The Covered Person shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the Covered Person has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the primary and Secondary Plans are less than the provider's billed charges. In no event shall the Covered Person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is AC Plan

If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is AC Plan or Fee Schedule Plan

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Covered Person receives from a non-network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or AC Plan

If the Covered Person receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or AC Plan and Secondary Plan is Capitation Plan

If the Covered Person receives services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the deductible, coinsurance or copayment imposed by the Primary Plan. The Covered Person shall not be liable to pay any deductible, coinsurance or copayments of either the Primary Plan or the Secondary Plan.

Primary Plan is an HMO and Secondary Plan is an HMO

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Covered Person receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan. Except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under this Policy when expenses are incurred as a result of an automobile related Injury.

Definitions
"Automobile Related Injury" means bodily Injury sustained by a Covered Person as a result of an accident:
a) while occupying, entering, leaving or using an automobile; or
b) as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:
a) this Policy;
b) PIP; or
c) OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under this Policy without application of Cash Deductibles and Copayments, if any or Coinsurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.
This Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under this Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Policy may be primary for one Covered Person, but not for another if the person has separate automobile policies and has made different selections regarding primacy of health coverage.

This Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case this Policy will be primary.

If there is a dispute as to which policy is primary, this Policy will pay benefits as if it were primary.

Benefits this Policy will pay if it is primary to PIP or OSAIC.
If this Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of this Policy will apply if:
a) the Covered Person is insured under more than one insurance plan; and
b) such insurance plans are primary to automobile insurance coverage.

Benefits this Policy will pay if it is secondary to PIP or OSAIC.

If this Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a) the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Copayments, or

b) the benefits that would have been paid if this Policy had been primary.

Medicare

If this Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to the Employer's Policy. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and this Policy will be the secondary health plan for Covered Persons who are eligible for Medicare.

The following provisions explain how this Policy's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:

a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

b) A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.

c) A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits** section for a definition of "allowable expense".

d) "We" means Carrier

MEDICARE ELIGIBILITY BY REASON OF AGE (Generally applies to employer groups with 20 or more employees)

Applicability

This section applies to an Employee or his or her insured spouse who is eligible for Medicare by reason of age. This section does not apply to an insured civil union partner or an insured domestic partner who is eligible for Medicare by reason of age.

Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible".

This section does not apply to:

a) a Covered Person, other than an Employee or insured spouse

b) an Employee or insured spouse who is under age 65, or

c) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare

When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose this Policy as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When This Policy is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under this Policy will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, Horizon BCBSNJ will pay benefits as if he or she had chosen Option (A).

When this Policy is primary
When a Medicare eligible chooses this Policy as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Policy. Coverage under this Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose this Policy as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY (Generally applies to employer groups with 100 or more employees)

Applicability
This section applies to a Covered Person who is:
a) under age 65; except for the Employee's civil union partner or domestic partner or the child of the Employee's civil union partner or domestic partner; and
b) eligible for Medicare by reason of disability.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a Covered Person who is eligible for Medicare by reason of age; or
b) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease; or
c) a Covered Person who is the Employee's civil union partner or domestic partner or the child of the Employee's civil union partner

When A Covered Person Becomes Eligible For Medicare
When a Covered Person becomes eligible for Medicare by reason of disability, this Policy is the primary plan. Medicare is the secondary plan.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS AND SERVICES** section of this Policy.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE (Applies to all employer groups)

Applicability
This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such Covered Person is referred to as a "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD
When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30 month period begins on the earlier of:
a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 30 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both this Policy and Medicare, Medicare is the primary Plan. This Policy is the secondary Plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. Benefits will be payable as specified in the **COORDINATION OF BENEFITS** section of this Policy.

HORIZON HEALTHCARE SERVICES, INC.

RIDER (DIRECT ACCESS-2/11)

Policyholder: MICHAEL S. LIBOCK, CPA, LLC
Group Policy No.: 475K3
Effective Date: JULY 1, 2011

This **Rider** permits Covered Persons to directly access Network Providers for covered services, treatment or supplies without a referral from a Primary Care Practitioner (PCP). A lower Copayment applies when a Covered Person receives services from a PCP. A higher Copayment applies when a Covered Person receives services from a professional other than a PCP.

While this Rider eliminates the requirement that a Covered Person obtain a referral from his or her PCP in order to receive Network Benefits for covered services, treatment or supplies, each Covered Person is encouraged to select a PCP and contact his or her PCP.

As described under "Required Hospital Stay Review" in the section "Important Notice" all Hospital admissions require prior notice. In the case of Hospital admissions for the treatment of Mental Illness or Substance Abuse, when the Care Manager (described below): manages; assesses; coordinates; directs; and authorizes a Covered Person's Inpatient treatment for a Mental Illness or Substance Abuse, coverage for that treatment will be provided at the Network level of benefits, unless, as part of this process, the Covered Person elects treatment from a Non-Network Provider. Coverage will always be provided at a reduced level if the Care Manager does not: manage; assess; coordinate; direct; and authorize a Covered Person's Inpatient treatment for a Mental Illness or Substance Abuse before expenses are incurred.

No benefits are payable with respect to any treatment that is not Medically Necessary and Appropriate.

1. The **SCHEDULE OF INSURANCE AND PREMIUM RATES** of the New Jersey Standard Small Employer Policy Indemnity POS Plan B is amended as follows:

a. The Class(es), Copayment and Emergency Room Copayment provisions are deleted and replaced by the following:

Class(es): All Eligible Employees.

Copayment

For treatment, services and supplies given by a Network Provider:

Preventive Care	None
Physician Visits (other than for Preventive Care)	
• Primary Care Physician	$20
• All Other Physicians	$40
Maternity (Pre-Natal Care)	$25 for initial visit only

Emergency Room (waived if admitted within 24 hours)	$100

Note: The Emergency Room Copayment is payable in addition to the applicable Deductible and Coinsurance.

b. The Calendar Year Cash Deductible provisions are deleted and replaced by the following:

Calendar Year Cash Deductible for services provided by a Network Provider :

For Preventive Care	None
For immunizations and lead screening for children	None
For Outpatient radiology services	None
For all other Covered Charges	
Per Covered Person	$1,500
Per Covered Family	$3,000 **Note**: Must be individually satisfied by two separate Covered Persons.

The Cash Deductible is waived for treatment, services or supplies provided in a Network Practitioner's office. The Cash Deductible is waived for laboratory services rendered by a Network Provider in a Network Provider's office or other Network setting, other than in a Hospital. The Cash Deductible is also waived for the Hospital emergency room charge and for Durable Medical Equipment received from a Network Provider.

Calendar Year Cash Deductible for services provided by a Non-Network Provider:

For Preventive Care	None
For immunizations and lead screening for children	None
For all other Covered Charges	
Per Covered Person	$2,500
Per Covered Family:	$5,000 **Note**: Must be individually satisfied by two separate Covered Persons.

c. The Coinsurance provisions are deleted and replaced by the following:

Coinsurance

Coinsurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, Horizon BCBSNJ will waive the Coinsurance requirement once the Network Maximum Out of Pocket has been reached with respect to Network services and supplies, and

Horizon BCBSNJ will waive the Coinsurance requirement once the Non-Network Maximum Out of Pocket has been reached with respect to Non-Network services and supplies. The Policy's Coinsurance, as shown below, does not include Cash Deductibles, Copayments, penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Coinsurance** for this Policy is as follows:

Treatment, services or supplies given by a Network Provider:

• Preventive Care	None
• Treatment, services or supplies provided in a Network Practitioner's office	None
• Laboratory services provided by a Network Provider in a Network Provider's office or other Network setting, other than in a Hospital	None
• Maternity services provided in a Network Practitioner's office	None
• Outpatient radiology services	None
• All other treatment, services or supplies, including Facility services, that are provided by a Network Provider	20%, except as stated below.

Treatment, services or supplies given by a Non-Network Provider:

• Preventive Care	None
• If treatment, services or supplies are given by a Non-Network Provider	40%, except as stated below.

Exception: The Coinsurance for Durable Medical Equipment does not vary according to the use of a Network Provider or a Non-Network Provider.

The Coinsurance for Durable Medical Equipment is:	50%

d. The Network Maximum Out of Pocket and Non-Network Maximum Out of Pocket provisions are replaced by the following:

Network Maximum Out of Pocket

Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Network Maximum Out of Pocket. Once the Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as

Copayment and Coinsurance for Network covered services and supplies for the remainder of the Calendar Year.

The **Network Maximum Out of Pocket** for the Policy is as follows:

Per Covered Person per Calendar Year	$3,000
Per Covered Family per Calendar Year	$6,000

Note: The Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

Non-Network Maximum Out of Pocket

Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Deductible and Coinsurance for all Non-Network covered services and supplies in a Calendar Year. All amounts paid as Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. Once the Non-Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Deductible and Coinsurance for Non-Network covered services and supplies for the remainder of the Calendar Year.

The **Non-Network Maximum Out of Pocket** for the Policy is as follows:

Per Covered Person per Calendar Year	$7,500
Per Covered Family per Calendar Year	$15,000

Note: The Non-Network Maximum Out of Pocket cannot be met with Non-Covered Charges.

e. The following are added under the heading “Preapproval is required for charges incurred in connection with”:

- The following Outpatient radiology services: Computed Tomography (CT); Computed Tomography Angiography (CTA); Magnetic Resonance Imaging (MRI); Magnetic Resonance Angiogram (MRA); Positron Emission Tomography (PET); Nuclear Medicine (including Nuclear Cardiology).

- Ambulance services for non-emergency transportation.

f. The following are added under the subheading “Payment Limits”:

Charges for Home Health Care, per Calendar Year	60 visits per Covered Person
Charges for Ambulatory Surgical Center, per Calendar Year (Non-Network only)	$2,000 per Covered Person

2. The subsection “The Cash Deductible“ in the section “Benefit Provision” is replaced by the following:

The Cash Deductible

The Policy has two different Cash Deductibles. One is for treatment, services or supplies given by a Network Provider. The other is for treatment, services or supplies given by a Non-Network Provider. Each Cash Deductible is shown in the Schedule.

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a Network Provider that exceed the Cash Deductible before Horizon BCBSNJ pays benefits for those types of Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a Network Provider, while insured by the Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, Horizon BCBSNJ pays benefits for other such Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Each Calendar Year, each Covered Person must have Covered Charges for treatment, services or supplies from a Non-Network Provider that exceed the Cash Deductible before Horizon BCBSNJ pays benefits for those types of Covered Charges to that Covered Person. Only Covered Charges incurred by the Covered Person for treatment, services or supplies from a Non-Network Provider, while insured by the Policy, can be used to meet this Cash Deductible. Once the Cash Deductible is met, Horizon BCBSNJ pays benefits for other such Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

Neither Cash Deductible can be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by the Policy can be used to meet either Cash Deductible. What Horizon BCBSNJ pays is based on all the terms of the Policy.

Family Deductible Limit

The Policy has two different family deductible limits. One is for treatment, services or supplies given by a Network Provider. The other is for treatment services or supplies given by a Non-Network Provider.

There is a family deductible limit of two Cash Deductibles for Covered Charges for treatment, services or supplies given by a Network Provider for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductible for treatment, services or supplies given by a Network Provider, Horizon BCBSNJ pays benefits for other such Covered Charges incurred by any member of that covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

There is a family deductible limit of two Cash Deductibles for Covered Charges for treatment, services or supplies given by a Non-Network Provider for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductible for treatment, services or supplies given by a Non-Network Provider, Horizon BCBSNJ pays benefits for other such Covered Charges incurred by any member of that covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year.

What Horizon BCBSNJ pays is based on all the terms of the Policy.

3. The section **DEFINITIONS** is modified by the addition of the following definition:

Specialty Pharmaceuticals: Oral or injectable drugs that have unique production, administration or distribution requirements. They require specialized patient education prior to

use and ongoing patient assistance while under treatment. These Prescription Drugs must be dispensed through Specialty Pharmaceutical Providers.

Examples of Prescription Drugs that qualify as Specialty Pharmaceuticals include those used to treat the following conditions: Chrohn's Disease; Infertility; Hemophilia; Growth Hormone Deficiency; RSV; Cystic Fibrosis; Multiple Sclerosis; Hepatitis C; Rheumatoid Arthritis; Gaucher's Disease.

4. The Point of Service Provisions of the New Jersey Standard Small Employer Policy POS Plan B are amended as follows:

   a. In the Definitions subheading a), "Primary Care Practitioner", the word "selects" is replaced with "may select".

   b. In the Definitions subheading c), the definition of "Network Benefits" is deleted and replaced with the following:

      Network Benefits mean the benefits shown in the Schedule which: are provided if the PCP, or Care Manager or another Network Provider provides care, treatment, services and supplies to the Covered Person; in the case of Facility benefits, when benefits are provided in a Network Facility; in the case of Non-Network Facility benefits, when the Covered Person is admitted or directed by his/her PCP or Care Manager; when benefits are provided by a free-standing Network laboratory or radiology Provider.

   c. In the Definitions subheading d), the definition of "Non-Network Benefits" is deleted and replaced with the following:

      Non-Network Benefits mean the benefits shown in the Schedule which: are provided if the PCP, Care Manager or another Network Provider does not provide the care, treatment, services and supplies; in the case of Facility benefits, are provided in a Non-Network Facility when not admitted or directed by his/her PCP or Care Manager.

   d. The following terms are added to the Definitions subheading:

      Care Manager means a person or entity designated by Horizon BCBSNJ to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment for a Mental Illness or Substance Abuse.

      Network Providers mean Providers that are in the "Horizon Managed Care" Provider Organization.

      Non-Network Providers mean Providers that are not in the "Horizon Managed Care" Provider Organization.

   e. In the subheading "Provider Organization (PO)", the second sentence is deleted and replaced with "The Policy requires that the Covered Person

use the services of a PCP, Care Manager or another Network Provider or Network Facility or, in the case of a Non-Network Facility, be admitted or directed by his/her PCP or Care Manager in order to receive Network Benefits."

f. All of the provisions under the subheading, "The Primary Care Practitioner (PCP)" are deleted and replaced with the following:

The Primary Care Practitioner (PCP)

Horizon BCBSNJ recommends that each Covered Person select a PCP to coordinate his or her health care in the Horizon PO. The PCP may provide services and supplies. The services of a PCP have a lower Copayment. In addition, he or she may refer the Covered Person to an appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person, though, is not required to obtain a referral from his or her PCP before he or she visits another Network Provider in order to receive Network Benefits. Except in case of Urgent Care or an Emergency, if the Covered Person does not comply with these requirements, he or she may only be eligible for Non-Network Benefits.

Horizon BCBSNJ provides Network Benefits for covered services and supplies furnished to a Covered Person when provided by his or her PCP, Care Manager or another Network Provider or Network Facility, or when admitted or directed by his or her PCP or Care Manager. Horizon BCBSNJ pays Non-Network Benefits when covered services and supplies are provided by a Non-Network Provider or Non-Network Facility when not admitted or directed by the PCP or Care Manager. However, if the PCP or Care Manager refers a Covered Person to a Non-Network Provider for a service or supply, the service or supply shall be covered as a Network service or supply and Horizon BCBSNJ is fully responsible for payment to the Provider. The Covered Person is only responsible for any applicable Network level Copayment, Coinsurance or Deductible for the service or supply.

A Covered Person may change his or her PCP to another PCP. He or she may select another PCP from the list of Practitioners and notify Horizon BCBSNJ by phone or in writing. For a discretionary change, the new PCP selection will take effect no more than 14 days following the date of the request. For a change necessitated by termination of the prior PCP from the Network, the new PCP selection will take effect immediately.

When a Covered Person uses the services of a PCP, Care Manager or other Network Provider, he or she must present his or her ID card and pay any required Copayment.

Most Network Providers will prepare any necessary claim forms and submit them to Horizon BCBSNJ.

g. The following new subheading and provisions are added immediately after the subheading "The Primary Care Practitioner (PCP)":

THE ROLE OF THE CARE MANAGER

We strongly recommend that a Care Manager manage a Covered Person's treatment for Mental Illness or Substance Abuse. A Covered Person should contact the Care Manager or the Covered Person's PCP when he or she needs treatment for one of these conditions. As described previously, a Covered Person must contact the Care Manager when he or she needs Inpatient Hospital treatment for one of these conditions. The Care Manager's phone number is listed on the Covered Person's identification card.

If selected, the Care Manager will manage, assess, coordinate, direct and authorize a Covered Person's treatment for Mental Illness or Substance Abuse. The Care Manager will also review and determine if treatment provided is Medically Necessary and Appropriate.

h. The paragraph under the subheading "Non-Network Services" is deleted and replaced with the following:

If a Covered Person uses the services of a Non-Network Provider, he or she will not be eligible for Network Benefits unless directed by his/her PCP or Care Manager. Except as stated below, the Covered Person may only be eligible for Non-Network Benefits. Exception: If a Covered Person is admitted to a Network Facility by a Non-Network Provider, the Network Facility will nevertheless be paid Network benefits.

i. In the subheading "Emergency Services", the first paragraph is deleted.

j. In the subheading "Emergency Services", the third paragraph is deleted and replaced with the following:

In the case of Urgent Care or an Emergency, a Covered Person may go to a Horizon BCBSNJ Network Provider or a Non-Network Provider. Follow-up care or treatment by a Non-Network Provider will be treated as Network Benefits only to the extent it is Medically Necessary and Appropriate care or treatment rendered before the Covered Person can return to the Service Area.

5. The **COVERED CHARGES** section is modified to provide that the following sentence is added as a separate paragraph at the end of the subsection **Prescription Drugs:**

Prescription Drugs classified as Specialty Pharmaceuticals always require Our Pre-Approval.

6. The section **EXCLUSIONS** is changed by the addition of the following exclusion:

Food products (including enterally administered food products, except when they are used as the sole source of nutrition). But this exclusion does not apply to the foods, food products and specialized non-standard infant formulas that are eligible for coverage in accordance with the subsections "Food and Food Products for Inherited Metabolic Disease" and "Specialized Infant Formulas".

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This Rider is part of the Policy. Except as stated above, nothing in this Rider changes or affects any other terms of the Policy. Attach this Rider to the Policy.

Horizon Healthcare Services, Inc. d/b/a
Horizon Blue Cross Blue Shield of New Jersey
By:

Al Bowles
Vice President
Commercial and Major Account Markets

HORIZON HEALTHCARE SERVICES, INC.

RIDER FOR PRESCRIPTION DRUG INSURANCE

Policyholder: **MICHAEL S. LIBOCK, CPA, LLC**
Group Policy No.: **475K3**
Effective Date: **JULY 1, 2011**

The Prescription Drug Coverage under this Rider replaces the Prescription Drug coverage specified under the Policy to which this Rider is attached when Prescription Drugs are obtained from either a Participating Pharmacy or a Participating Mail Order Pharmacy.

Subject to Horizon BCBSNJ's Pre-Approval of certain Prescription Drugs, Horizon BCBSNJ covers Prescription Drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription. But Horizon BCBSNJ only covers drugs which are:

a) approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;

b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

- The American Hospital Formulary Service Drug Information;
- The United States Pharmacopeia Drug Information; or

c) recommended by a clinical study or recommended by a review article in a major peer reviewed professional journal.

Coverage for the above Prescription Drugs also includes Medically Necessary and Appropriate services associated with the administration of the Prescription Drugs.

In no event will Horizon BCBSNJ pay for:

a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or

b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed, except as otherwise stated above.

And Horizon BCBSNJ excludes drugs that can be bought without a prescription, except for insulin, even if a Practitioner orders them.

DEFINITIONS

Brand Name Drug means:

a) a Prescription Drug, as determined by the Food and Drug Administration; and

b) a drug that is protected by the trademark registration of the pharmaceutical company that produces it.

Generic Drug means:

a) a therapeutically equivalent Prescription Drug, as determined by the Food and Drug Administration;

b) a drug which is used unless the Practitioner prescribes a Brand Name Drug; and

c) a drug which is identical to the Brand Name Drug in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from:

a) a Participating Mail Order Pharmacy by ordering the drugs through the mail, or

b) a Participating Pharmacy that has agreed to accept the same terms, conditions, price and services as a Participating Mail Order Pharmacy.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Non-Preferred Drug means a Prescription Drug that is not included on Horizon BCBSNJ's list of Preferred Drugs.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by Horizon BCBSNJ, or with which Horizon BCBSNJ has signed a pharmacy service agreement, that is:

a) equipped to provide Prescription Drugs through the mail; or

b) a Participating Pharmacy that is willing to accept the same pharmacy agreement terms, conditions, price and services as exist in the Participating Mail Order Pharmacy agreement.

Participating Pharmacy means a licensed and registered pharmacy operated by Horizon BCBSNJ or with which Horizon BCBSNJ has signed a pharmacy service agreement.

Preferred Drug means a Prescription Drug that:

a) has been designated as such by either Horizon BCBSNJ's pharmacy and therapeutics committee, or by a third party with which Horizon BCBSNJ contracts, as a Preferred Drug;

b) is a drug that has been approved under the Federal Food, Drug and Cosmetic Act; and

c) is included on the list of Preferred Drugs distributed to providers and made available to Covered Persons, upon request. The list of preferred Drugs will be revised, as appropriate.

Prescription Drug means:

a) Legend Drugs;

b) compound medications of which at least one ingredient is a Legend Drug;

c) insulin; and

d) any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution-Federal Law prohibits dispensing without a prescription."

PRE-APPROVAL REQUIREMENT

Horizon BCBSNJ has identified certain Prescription Drugs for which Pre-Approval is required. Horizon BCBSNJ will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee. Horizon BCBSNJ will give at least 30 days advance written notice to the Employee before revising the list of Prescription Drugs to add a Prescription Drug to the list.

If a Covered Person brings a prescription for a Prescription Drug for which Horizon BCBSNJ requires Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, the Covered Person must contact Horizon BCBSNJ to request Pre-Approval. The Pharmacy will contact the Practitioner to request that the Practitioner contact Horizon BCBSNJ to secure Pre-Approval. The Pharmacy will dispense a 96-hour supply of the Prescription Drug. Horizon BCBSNJ will review the Pre-Approval request within the time period allowed by law. If Horizon BCBSNJ gives Pre-Approval, Horizon BCBSNJ will notify the Pharmacy, and the balance of the Prescription Drug will be dispensed with benefits for the Prescription Drug being paid subject to the terms of the Policy. If Horizon BCBSNJ does not give Pre-Approval, the Covered Person may ask that the Pharmacy dispense the balance of the Prescription Drug, with the Covered Person paying for the Prescription Drug. The Covered Person may submit a claim for the Prescription Drug, subject to the terms of the Policy. The Covered Person may appeal a denial by following the Appeals Procedure process set forth in the Policy.

COPAYMENT

A Covered Person must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy. A Copayment must be paid before any benefit will be paid for the Prescription Drug.

The Copayment for each prescription or refill which is not obtained through the Mail Order Program is:

- for Generic Preferred Drugs: $15.00 per up to a 30-day supply;
- for Brand Name Preferred Drugs: $40.00 per up to a 30-day supply;
- for Generic Non-Preferred Drugs and Brand Name Non-Preferred Drugs: $75.00 per up to a 30-day supply.

The Copayment for each prescription or refill which is obtained through the Mail Order Program is:

- for Generic Preferred Drugs: $30.00 per up to a 90-day supply;
- for Brand Name Preferred Drugs: $100.00 per up to a 90-day supply;
- for Generic Non-Preferred Drugs and Brand Name Non-Preferred Drugs; $200.00 per up to a 90-day supply.

Horizon BCBSNJ will pay the Covered Charge in excess of the Copayment for each Prescription Drug dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy while the Covered Person is insured. What Horizon BCBSNJ pays is subject to all the terms of the Policy.

A Covered Person and his or her Practitioner may request that a Non-Preferred Drug be covered subject to the applicable Copayment for a Preferred Drug. Horizon BCBSNJ will consider a Non-Preferred Drug to be Medically Necessary and Appropriate if:

a) It is approved under the Federal Food, Drug and Cosmetic Act; or its use is supported by one or more citations included or approved for inclusion in The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia-Drug Information, or it is recommended by a clinical study or review article in a major peer-reviewed journal; and

b) The Practitioner states that all Preferred Drugs used to treat the Illness or Injury have been ineffective in the treatment of the Covered Person's Illness or Injury, or that all drugs have caused or are reasonably expected to cause adverse or harmful reactions in the Covered Person.

Horizon BCBSNJ shall respond to the request for approval of a Non-Preferred Drug within one business day and shall provide written confirmation within five business days. Denials shall include the clinical reason for the denial. The Covered Person may follow the Appeals Procedure set forth in the Policy. In addition, the Covered Person may appeal a denial to the Independent Health Care Appeals Program at the Department of Health and Senior Services.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

a) prescribed by a Practitioner (except for insulin);

b) dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy; and

c) needed to treat an Illness or Injury.

Such charges will not include charges made for more than:

a) a 90-day supply for each prescription or refill which is not obtained through the Mail Order Program where the Copayment is calculated based on the multiple of 30-day supplies received;

b) a 90-day supply of a Maintenance Drug obtained through the Mail Order Program where the Copayment is the Copayment specified for a 90-day supply; and

c) the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

OTHER CHARGES

Horizon BCBSNJ will not restrict or prohibit, directly or indirectly, a Participating Pharmacy or a Participating Mail Order Pharmacy from charging the Covered Person for charges that are in addition to charges for the Prescription Drug, for dispensing the Prescription Drug or for prescription counseling, provided such other charges have been approved by the New Jersey Board of Pharmacy, and the amount of the charges for the additional services and the purchaser's out-of-pocket cost for those services has been disclosed to the Covered Person prior to dispensing the drug.

EXCLUSIONS

Horizon BCBSNJ will not pay for any of the following:

a) Charges to administer a Prescription Drug.

b) Charges for: immunization agents; biological sera; blood or blood plasma.

c) Charges for a Prescription Drug which is: labeled "Caution - limited by Federal Law to Investigational use"; or experimental.

d) Charges for refills in excess of that specified by the prescribing Practitioner.

e) Charges for refills dispensed after one year from the original date of the prescription.

f) Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.

g) Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in: a Hospital; a rest home; a sanitarium; an Extended Care Facility; a Hospice; a Substance Abuse Center; an alcohol abuse or mental health center; a convalescent home; a nursing home; or similar institution.

h) Charges for: therapeutic devices or appliances; hypodermic needles; syringes, except insulin syringes; support garments; and other non-medical substances, regardless of their intended use.

i) Charges for vitamins, except Legend Drug vitamins.

j) Charges for drugs for the management of nicotine dependence.

k) Charges for topical dental fluorides.

l) Charges for any drug used in connection with baldness.

m) Charges for drugs to enhance normal functions, such as: (i) steroids used to enhance athletic performance; (ii) memory enhancing drugs; (iii) drugs used for generalized hormone replacement therapy to improve well-being; (iv) drugs for anti-aging; and (v) drugs or hormones to promote growth in the absence of an Illness, Injury or congenital condition, such as growth hormone deficiency.

n) Charges for drugs to treat sexual dysfunction.

o) Charges for acne agents and both non-sedating and regular antihistamines for which there are exact over-the-counter equivalents.

p) Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.

q) Charges for drugs dispensed to a Covered Person while on active duty in any armed force.

r) Charges for drugs for which there is no charge. This usually means drugs furnished by: the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and Horizon BCBSNJ is legally required to pay it, Horizon BCBSNJ will.

s) Charges for drugs covered under the Policy to which this Rider is attached which are covered under the Home Health Care or Hospice Care sections of the Policy.

t) Charges for drugs provided to treat an Injury or Illness suffered: (a) as a result of War or an Act of War, if the injury or Illness occurs while the Covered Person is serving in the military, naval or air forces of any country, combination of countries or international organization; and (b) as a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the Injury or Illness occurs while the Covered Person is serving in such forces and is outside the Home Area.

"War", as used herein and below, includes, but is not limited to, declared war and armed aggression by one or more countries resisted on orders of any other country, combination of countries or international organization.

"Act of War", as used herein and below, means any act peculiar to military, naval or air operations in time of War.

"Home Area", as used herein and below, means the 50 states of the United States of America, the District of Columbia and Canada.

u) Charges for drugs provided to treat an Injury or Illness suffered: (a) as a result of War or an Act of War while the Covered Person is serving in any civilian non-combatant unit supporting or accompanying any military, naval or air forces of any country, combination of countries or international organization; and (b) as a result of the special hazards incident to such service, provided the Injury or Illness occurs while (i) the Covered Person is serving in such unit; and (ii) is outside the Home Area.

v) Charges for drugs provided to treat an Injury or Illness suffered as a result of War or an Act of War while the Covered Person is not in the military, naval or air forces of any country, combination of countries or international organization or in any civilian non-combatant unit supporting or accompanying such forces, if the Injury or Illness occurs outside the Home Area.

w) Except as stated below, charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

Exception: This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional, unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership; members of a limited liability company

or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

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This Rider is part of the Policy. Except as stated above, nothing in this Rider changes or affects any other terms of the Policy. Attach this Rider to the Policy.

Horizon Healthcare Services, Inc. d/b/a
Horizon Blue Cross Blue Shield of New Jersey
By:

Al Bowles
Vice President
Commercial and Major Account Markets